

BGSU STUDENT HEALTH SERVICE ("SHS")
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____
Local Address: _____
City/State/Zip Code: _____
P0 _____ Phone No. (_____) _____
Date of Request: _____ Date Needed: _____

Release of Records *

I authorize the SHS to **RELEASE** records to:
Provider/Facility: _____
Attn: _____
Address: _____
City/State/Zip Code: _____
Phone No: (_____) _____
Fax No: (_____) _____

-OR-

Obtaining Records

I authorize the SHS to **OBTAIN** records from the
provider/facility named below:
Provider/Facility: _____
Attn: _____
Address: _____
City/State/Zip Code: _____
Phone No: (_____) _____ Fax No: (_____) _____

* **NOTICE:** Please note that once the requested records are provided to another party by the SHS those records may be subject to re-disclosure and not protected by this Authorization and certain Federal regulations dealing with the privacy of individually identifiable health information (45 CFR Part 164, Subpart E).

RELEASE OF RECORDS TO SELF:

I am requesting the Student Health Service (SHS) to release the records described below to myself as the Patient or Personal Representative of the Patient.

TYPE OF RECORDS REQUESTED:

The records requested are the following (check all that apply):*

- Entire copy of medical records from (date) _____ to (date) _____
*This will include information about behavioral and/or mental health services and information regarding treatment for alcohol and drug abuse unless specified otherwise below.
 - Exceptions _____
- Immunization History
- All medical records related to the specific illness or injury listed below:
_____ from (date) _____ to (date) _____
- Include records from other providers and facilities
- Other (be specific): _____
- I authorize the SHS to include information about the diagnosis and treatment of HIV.

THIS AUTHORIZATION EXPIRES (DATE): _____

(This date cannot be later than 60 days after the date of request)

***Fees:** Depending upon the nature and extent of records requested, the SHS may charge fees for the preparation, reproduction, and postage costs involved with your request. These costs will be assessed in an amount consistent with the provisions of the Ohio Revised Code §3701.741 and Title 45 Code of Federal Regulations §164.524(c)(4). The SHS will explain these charges to you before processing your request.

PURPOSE FOR THIS REQUEST:

- At request of Patient
- At request of Patient's Personal Representative *
- Other (describe) _____

I authorize the SHS to release/obtain and make use of the Patient's protected health information and medical records described in this Authorization.

Signature: _____ **Date:** _____

*My authority to act as the Personal Representative of the Patient is based on the following:

YOUR RIGHTS:

This Authorization may be revoked by signing where indicated below. Neither your subsequent revocation nor your refusal to sign this Authorization will be used as a basis to deny the Patient any treatment, service, or benefit otherwise available to the Patient as a BGSU student.

I **REVOKE** the above Authorization.

Signature: _____

Date: _____

*(This Authorization includes *BGSU's Student Health Service Privacy Policy Notice* found at: www.bgsu.edu/health)

ADMINISTRATIVE:

To be completed by an employee of the Student Health Service

Date revocation received by the Student Health Service: _____

Date Request Received: _____

Circle one: Records Mailed Records Picked Up Records Faxed Records Denied

Charge: _____

Employee Signature: _____

Date Request Completed: _____